Injection Drug Codes

MAA's fees for Injectable Drug Codes are the maximum allowances used to reimburse covered drugs and biologicals administered incident to a provider's professional service. MAA follows the Centers for Medicare & Medicaid's (CMS) payment policy used by Medicare to set the maximum allowances.

MAA obtains the Average Wholesale Price (AWP) for most of the HCPCS level II drug and biological codes from the Part B Medicare Carrier for Washington. MAA implements updates to the rates from the Medicare carrier on a quarterly basis. Unlike Medicare, the MAA effective dates are based on dates of service, not the date the claim was received. For codes where the Medicare Carrier has not established a rate, MAA determines the maximum allowances for covered drugs using the following methodology:

Pricing Methodology

1. For a single-source drug or biological, the AWP equals the AWP of the single product.
2. For a multi-source drug or biological, the AWP is equal to the lesser of the median AWP of all of the generic forms of the drug or biological or the lowest brand name product AWP. A "brand-name" product is defined as a product that is marketed under a labeled name that is other than the generic chemical name for the drug or biological.
3. After determining the AWP according to #1 and #2 above, the amount is multiplied by 0.95 for chemotherapy drugs, and 0.89 for all other drugs to arrive at the fee schedule maximum allowance.

When billing for the drugs and biologicals, providers must use the descriptions of the procedure code and include the correct number of units on the claim form in order to be reimbursed the appropriate amount. For drugs that are priced at "acquisition cost," providers must include a copy of the manufacturer's invoice if the total charge of the claim exceeds $1,100.00. If the total charges are equal to or less than $1,100.00, providers must retain a copy of the manufacturer's invoice in the client's record. Do not bill unclassified or unspecified drug codes unless there is no specific code for the drug being administered. The name, National Drug Code (NDC), strength, dosage, and quantity of the drug must be included with the unclassified or unspecified drug code for coverage and payment consideration.

HCPCS codes J8499 and J8999 for oral prescription drugs are not covered.

Injectable drugs can be injected subcutaneously, intramuscularly, or intravenously. The injectable drugs can be billed only out of the physician's office supply. Name, strength and dosage of the drug must be documented and retained in the client's record.

Chemotherapy Drug (J9000-J9999)

- Bill number of units used based on the description of the drug code. For example, if 250 mg of Cisplatin (J9062) is given to the patient, the correct number of units is five (5).
- Claims with HCPCS code J9999 must include drug used, dosage, strength and NDC in the *Comments* field.
- Maximum allowable fee is 95% of the Average Wholesale Price (AWP).

All Other Drugs

- Bill number of units used based on the description of the drug code. For example, if 20 mg of Hyalgan (J7316) is given to the patient, the correct number of units is four (4).
- Claims with HCPCS code J3490 must include drug used, dosage, strength and NDC in the *Comments* field.
- Maximum allowable fee is 89% of the AWP.

Prior Authorization

Those drugs that require written/fax prior authorization are noted in the fee schedule with a "PA" next to them. For information on how to request prior authorization, please see section I.

Rounding of Units

The following guidelines should be used to round the dosage given to the patient to the appropriate number of units for billing purposes:

I. **Single-Dose Vials:**

For single-dose vials, bill the total amount of the drug contained in the vial(s) used including partial vials. The HCPCS descriptions for the drug codes establish the unit of service. Based on this unit definition, the maximum allowable per unit is MAA's maximum allowable price. MAA's payment is the billed amount or MAA's maximum allowable rate, whichever is less.

Example:

If a total of 150 mg of Etoposide were required for the therapy, and two 100 mg single dose vials were required to obtain the total dosage, then the total of the two 100 mg vials would be billable. In this case, the procedure would be billed under J9181 (Etoposide, 10 mg), with the maximum allowable price at $4.38 per 10 mg unit, the total allowable would be $87.60 (200 mg divided by 10 = 20 units x $4.38). This would then be compared to the billed amount.

II. Multi-Dose Vials:

For multi-dose vials, bill only the number of units (rounded to the nearest whole unit) of the drug used. The HCPCS descriptions for the drug codes establish the unit of service. Based on this unit definition, the maximum allowable per unit is MAA's maximum allowable price. MAA's payment is the billed amount or MAA's maximum allowable rate, whichever is less.

Example:

If a total of 750 mg of Cytarabine were required for the therapy, and was taken from a 2,000 mg multi-dose vial, then only the 750 mg used would be billable. In this case, the procedure would be billed under J9110 (Cytarabine, 500 mg), with the maximum allowable price at $23.75 per 500 mg unit, the total allowable would be $47.50 [750 mg divided by 500 = 2 (1.5 rounded) units x $23.75].

III. Unlisted Drugs (J3490 and J9999):

When there is no HCPCS code available to define the drug used and unit of service, the provider determines the number of units used and bills total units. Claims must include the drug used, dosage, strength and NDC in the *Comments* field. Claims will be denied if the information is not included on the claim. The NDC for the drug determines the total allowable by using MAA's pricing multiplied by the number of units billed. The same policies regarding the billing of single and multi-dose vials apply. Reimbursement is the billed amount or MAA's maximum allowable rate, whichever is less.

☞ **NOTE: The list of all injection drug codes and maximum allowable fees has been moved to the complete fee schedule section (Section J)**

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